Part 11: RFA Policies

Sections 11.1 – 11.3

Section 11.1: Environmental Modification Policy

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Environmental Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Autism (AU) – Division of Disability and Rehabilitative Services

Developmentally Disabled (DD) – Division of Disability and Rehabilitative Services

Note: Not a covered service for the Support Services (SSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Environmental Modifications.

Description

Environmental modifications are minor physical adaptations to the home, as required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB), which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

A lifetime cap of $15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the $15,000 lifetime cap, $500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a Home and Community Based Services (HCBS) waiver.

Home Ownership

Environmental modifications shall be approved for the individual's own home or family owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All environmental modifications must be approved by the waiver program prior to services being rendered.

Environmental modification requests must be provided in accordance with applicable State and/or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation.

Environmental modifications shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home;
- The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) home modification bids must be obtained for all modifications over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For modifications under $1,000, one (1) bid is required and pricing must be consistent with the fair market price for such modification(s);
- Bids must be itemized to include the following:

Example:

Scope of work	Material	Related Labor
Ramp 15' long	$$	$$
Widen front door to 36"	$$	$$
Widen bathroom door to 36"	$$	$$
Install ADA toilet	$$	$$
Building permits (specify)	$$	$$
Total Cost	$$$$	$$$$

Requests for modifications at two or more locations may only be approved at the discretion of the State division director or State agency designee.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

Service Standards

Environmental Modification must be of direct medical or remedial benefit to the individual;

To ensure that environmental modifications meet the needs of the individual and abide by established federal, state, local and FSSA standards, as well as ADA requirements, when applicable, approved environmental modifications will include:

- Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications;
- Independent inspections during, as well as at the completion of, the modification process, prior to authorization for reimbursement;
- Modifications must meet applicable standards of manufacture, design and installation;
- Modifications must be compliant with applicable building codes.

Documentation Standards:

The identified direct benefit or need must be documented within:

- POC/CCB; and
- 2. Physician prescription and/or clinical evaluation as deemed appropriate; and
- Individual Support Plan (ISP) if under the DD and AU waivers.

Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

- Property owner of the residence where the requested modification is proposed;
- Property owner's relationship to the individual;
- What, if any, relationship the property owner has to the waiver program;
- Length of time the individual has lived at this residence;
- If a rental property - length of lease;
- Written agreement of landlord for modification;
- Verification of individual's intent to remain in the setting; and
- Land survey may be required when exterior modification(s) approach property line.
- Signed and approved RFA;
- Signed and approved POC/CCB;
- Provider of services must maintain receipts for all incurred expenses related to the modification;
- Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for modifications which satisfy each of the following:

- Service and documentation standards outlined within this policy;

- Allowable under current Medicaid waiver guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service);
- Completed in accordance with the applicable Building permits.

Modifications/Items – Covered

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

Adaptive door openers and locks - limited to one (1) per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.

- Bathroom Modification **-** limited to one (1) existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
  - removal of existing bathtub, toilet and/or sink;
  - installation of roll in shower, grab bars, ADA toilet and wall mounted sink;
  - installation of replacement flooring, if necessary due to bath modification.

- Environmental Control Units - Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

- Environmental safety devices limited to:
  - door alarms;
  - anti-scald devices;
  - hand held shower head;
  - grab bars for the bathroom.

- Fence - limited to 200 linear feet (individual must have a documented history of elopement);

- Ramp - limited to one per individual primary residence, and only when no other accessible ramp exists:
  - In accordance with the Americans with Disabilities Act (ADA) or ADA Accessibility Guidelines (ADAAG), unless this is not in the best interest of the client;
  - Portable - considered for rental property only;
  - Permanent – must be a wooden structure;
    Vertical lift - may be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used.

- Stair lift – if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and ISP under AU and DD waiver);

- Single room air conditioner (s) / single room air purifier (s) – if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and ISP under AU and DD waiver):
    - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
    - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.

- Widen doorway **-** to allow safe egress:
    - Exterior - modification limited to one per individual primary residence when no other accessible door exists;
    - Interior - modification of bedroom, bathroom, and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).

- Windows - replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical/behavioral reason (s);

- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring etc. will be matched (to the degree possible) to the previous color/style/design;

- Maintenance - limited to $500 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
    - Requests for service must detail parts cost and labor cost;
    - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

- Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee

Modifications/Items – Non-Covered

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following, such as:

- Adaptations or improvements which are not of direct medical or remedial benefit to the individual:

    - central heating and air conditioning;

- routine home maintenance;
- installation of standard (non-ADA or ADAAG) home fixtures (e.g., sinks, commodes, tub, wall, window and door coverings, etc.) which replace existing standard (non-ADA or ADAAG) home fixtures;
- roof repair;
- structural repair;
- garage doors;
- elevators;
- ceiling track lift systems;
- driveways, decks, patios, sidewalks, household furnishings;
- replacement of carpeting and other floor coverings;
- storage (e.g., cabinets, shelving, closets), sheds;
- swimming pools, spas or hot tubs;
- video monitoring system;
- adaptive switches or buttons to control devices intended for entertainment, employment, or education;
- home security systems.

- Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);
- Modifications that duplicate existing accessibility (e.g., second accessible bathroom, a second means of egress from home, etc.);
- Modifications that will add square footage to the home;
- Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);
- Individuals living in a provider owned residence are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);
- Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification.

Decision Making Authority:

Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing, working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and Division specific guidelines and/or policies. Additionally, the case manager must

submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.

Section 11.2: Specialized Medical Equipment and Supplies

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Specialized Medical Equipment and Supplies Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Autism (AU) – Division of Disability and Rehabilitative Services

Developmentally Disabled (DD) – Division of Disability and Rehabilitative Services

Support Services (SSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Specialized Medical Equipment and Supplies (SMES).

Description

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB) which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Under the SSW waiver, a lifetime cap of $7,500 is available for Specialized Medical Equipment and Supplies.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.

Individuals requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA).

- There should be no duplication of services between HCBS waiver and Medicaid State Plan;
- The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
- Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service/brand;
- Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;

- Refer to 405 IAC 5-19 (attached) for additional information regarding Medicaid State Plan coverage. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The request is the most cost effective or conservative means to meet the individual's specific need(s);
- The request is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) bids must be obtained for items over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For requested items under $1,000, one (1) bid is required and pricing must be consistent with the fair market price;
- Bids must be itemized to include the following: picture of the product and detailed product information, including make/model number of the item.

Example:

Scope	Make/Model #	Material
Adapted plates/bowls		$$
Interpreter service		$$
Wheelchair		$$
Portable generator		$$
Total Cost		$$$$$

Requests will be denied if the State division director, or State agency designee determines the documentation does not support the service requested.

Service Standards

- Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual;
- All items shall meet applicable standards of manufacture, design and service specifications;
- Under the DD, AU, and SSW, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

Documentation standards include the following:

- The identified direct benefit or need must be documented within:
  - POC/CCB; and
  - Physician prescription and/or clinical evaluation as deemed appropriate; and
  - Individual Support Plan (ISP) under the DD, AU, and SSW.
- Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;
- Signed and approved Request for Approval to Authorize Services (RFA);
  Signed and approved POC/CCB;
  Provider of services must maintain receipts for all incurred expenses related to this service;
  Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for Specialized Medical Equipment and Supplies which satisfy each of the following:

- Service and documentation standards outlined within this policy;
- Allowable under current Medicaid waiver guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service).

Items - Covered

Justification and documentation is required to demonstrate that the request is necessary in order to meet the individual's identified need(s).

- Communication Devices - computer adaptations for keyboard, picture boards, etc.

- RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

- Generators (portable) - when either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one (1) generator per individual per ten (10) year period;

- Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning(e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision;

- Self help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist;

- Strollers - when needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;
- Manual wheelchairs - when required to facilitate safe mobility. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;
- Maintenance - limited to $500 annually for the repair and service of items that have been provided through a HCBS waiver:

    - Requests for service must detail parts cost and labor cost;

- If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

- Posture chairs and feeding chairs - as prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

- Vehicle Modifications **(**VMOD) - are administered under separate and independent waiver policy (Vehicle Modification Policy).

Items – Non-Covered
The following items and equipment:

- hospital beds, air fluidized suspension mattresses/beds;
- therapy mats;
- parallel bars;
- scales;
- activity streamers;
- paraffin machines or baths;
- therapy balls;
- books, games, toys;
- electronics – such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
- computers and software;
- adaptive switches and buttons;
- exercise equipment such as treadmills or exercise bikes;
- furniture;
- appliances - such as refrigerator, stove, hot water heater;
- indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
- swimming pools, spas, hot tubs, portable whirlpool pumps;
- temperpedic mattresses, positioning devices, pillows;
- bathtub lifts;
- motorized scooters;
- barrier creams, lotions, personal cleaning cloths;
- totally enclosed cribs and barred enclosures used for restraint purposes; medication dispensers.
- Any equipment or items that can be authorized through Medicaid State Plan;
- Any equipment or items purchased or obtained by the individual, his/her family members, or other non-waiver providers.

Note: In rare circumstances, a new or unanticipated item may be presented for consideration as a covered item under this service. **Prior to submission** of an RFA for this item, a written proposal justifying the need for this item must be sent to the OMPP for submission to the FSSA Policy Governance Board for consideration and determination of appropriateness as a Covered Item. The written proposal should be directed to:

Director of Agency Coordination and Integration
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W382
Indianapolis, IN 46204-2739.

These requests should be extremely rare and should not include items on the Non-Covered list, which have been previously vetted at the State, and determined to be Non-Covered items.

Decision Making Authority:

- Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing; working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and the Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
  - a corrective action plan;
  - reimbursement to Medicaid;
  - loss of decision making authority.

Section 11.3: Vehicle Modification

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Vehicle Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Autism (AU) – Division of Disability and Rehabilitative Services

Developmentally Disabled (DD) – Division of Disability and Rehabilitative Services

Support Services (SSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Vehicle Modifications.

Description

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget (POC/CCB), may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an individual to attend post secondary education or job related services should be referred to Vocational Rehabilitation Services.

A lifetime cap of $15,000 is available for vehicle modifications under the AD, AU, DD, and TBI waivers. Under the SSW waiver, a lifetime cap of $7,500 is available for Specialized Medical Equipment, which includes vehicle modifications. In addition to the applicable lifetime cap, $500 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

Vehicle Ownership

The vehicle to be modified must meet all of the following:

- The individual or primary caregiver is the titled owner;
- The vehicle is registered and/or licensed under state law;
- The vehicle has appropriate insurance as required by state law;
- The vehicle is the individual's sole or primary means of transportation;
- The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider agency.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All vehicle modifications must be approved by the waiver program prior to services being rendered.

Vehicle modification requests must meet and abide by the following:

- The vehicle modification is based on, and designed to meet, the individual's specific need(s);
- Only one vehicle per an individual's household may be modified;
- The vehicle is less than ten (10) years old and has less than 100,000 miles on the odometer;
- If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.

All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's specific need(s);
- The modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) modification bids must be obtained for all modifications over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For modifications under $1,000, one (1) bid is required and pricing must be consistent with the fair market price for such modification (s);
  - All bids must be itemized to include the following:

Example:

Make: Model: Mileage: Year:		
Scope of work	**Materials Cost**	**Related Labor**
Lift	$$	$$
Tie down	$$	$$
Total Cost:	$$$$$	

Many automobile manufacturers offer a rebate of up to $1,000 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support the service requested.

Service Standards

- Vehicle Modification must be of direct medical or remedial benefit to the individual;
- All items must meet applicable manufacturer, design and service standards.
- Under the DD, AU, and SSW, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist,

physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

The identified direct benefit or need must be documented within:

- POC/CCB; and
- Physician prescription and/or clinical evaluation as deemed appropriate; and
- Individual Support Plan (ISP) if under the DD, AU, and SSW.

Documentation/explanation of service within the Request for Approval to Authorize Services (RFA) must include:

- ownership of vehicle to be modified; or
- vehicle owner's relationship to the individual; and
- make, model, mileage, and year of vehicle to be modified.
  Signed and approved RFA;
  Signed and approved POC/CCB;
  Provider of services must maintain receipts for all incurred expenses related to the modification;
  Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for modifications which satisfy each of the following:

- Service and documentation standards outlined within this policy;
  Allowable under current Medicaid Waiver Guidelines;
  Not available under the Rehabilitation Act of 1973, as amended;
  Included in the individual's approved POC/CCB;
  Authorized on the RFA and linked to the POC/CCB;
  Included on a State approved and signed Notice of Action (NOA);
  Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service).

Modifications/Items - Covered

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

- Wheelchair lifts;
- Wheelchair tie-downs (if not included with lift);
- Wheelchair/scooter hoist;
- Wheelchair/scooter carrier for roof or back of vehicle;
- Raised roof and raised door openings;
- Power transfer seat base (Excludes mobility base);

Maintenance is limited to $500 annually for repair and service of items that have been funded through a HCBS waiver:

- Requests for service must differentiate between parts and labor costs;
- If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

Modifications/Items – Non-Covered

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following:

- Lowered floor van conversions;
- Purchase, installation, or maintenance of CB radios, cellular phones, global positioning/tracking devices, or other mobile communication devices;
- Repair or replacement of modified equipment damaged or destroyed in an accident;
- Alarm systems;
- Auto loan payments;
- Insurance coverage;
- Drivers license, title registration, or license plates;
- Emergency road service;
- Routine maintenance and repairs related to the vehicle itself.

Decision Making Authority:

- Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing; working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and the Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.